

Studdert et al., "Medical Malpractice"

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Studdert, David M., Michelle M. Mello, and Troyen A. Brennan, "Medical Malpractice." *New England Journal of Medicine* 350(3):283-292. 2004.

Framework and goals of the system

- malpractice law is part of tort law
- plaintiff must prove that
 - the defendant owed a duty of care to the plaintiff
 - the defendant breached this duty by failing to adhere to the standard of care expected
 - the breach of duty caused an injury to the plaintiff
- to evaluate whether the breach in question is negligence use medical custom determined through expert testimony
- there is some shifts from custom toward more independent determination of the court
- social goals of malpractice litigation:
 - deter unsafe practices
 - compensate persons injured through negligence
 - exact corrective justice
- hospitals and physicians are usually insured with deep coverage
- factors linked to patients' decisions to bring malpractice claims:
 - patient dissatisfaction
 - physicians' communication and interpersonal skills
- attorneys are the gatekeepers of the system
 - work on a contingency-fee basis (usually around 35% of award)

- attorneys absorb the costs of litigation, so need to think carefully about which cases to take
- in theory, system is efficient
 - courts provide compensation and deterrence
 - plaintiff’s attorneys serve as gatekeepers
 - liability coverage ensures that providers are not bankrupted by a single large payouts

The evolution of malpractice litigation

- malpractice litigation started to grow in the 1960s and 1970s
 - judges discarded rules that were obstacles to litigation
 - rolled back charitable immunity for hospitals
 - moved towards national standards of care
 - abandoned strict interpretations of the “locality rule”
 - expansion of doctrines like informed consent and res ipsa loquitur
 - synergistic effects of changes in legal doctrine, advances in medical science and the development of more coherent and visible standards of care
 - surges of litigation and plaintiffs’ victories
 - large variation across states
- as a consequence claims and insurance premiums soared and major insurers left the malpractice market
- this led to tort and insurance reforms (e.g., public underwriting and reinsurance)
- another wave of rise in litigation in the 1980s led to further tort reform, e.g., caps on noneconomic and punitive damages
- changes in the market for professional liability insurance:
 - growth of institutional self-insurance
 - “bedpan mutuals”: insurance companies owned and managed by physicians with medical malpractice as sole line of business
- 1990s were calmer with little growth in claim rates, steady but manageable increases in settlement amounts, slow or nonexistent premium growth

Empirical research on the malpractice system

- Medical Insurance Feasibility Study (1973)
 - reviewed 21,000 medical records from 23 California hospitals
 - 4.6% of hospitalizations involved iatrogenic injury
 - 0.8% of hospitalizations involved injury that would give rise to a finding of negligence in court
 - 10 times as many negligent injuries as malpractice claims
- Harvard Medical Practice Study (1990)
 - reviewed 30,000 hospital discharges and 3,500 malpractice claims from New York
 - rate of adverse events: 3.7%
 - rate of negligent adverse events: 1%
 - extrapolating, negligent care caused 20,000 disabling injuries and 7,000 deaths in New York hospitals in 1984
 - 7.6 times as many negligent injuries as claims
 - only 2% of negligent injuries resulted in claims
 - only 17% of claims appeared to involve negligent injury
- similar findings in Utah and Colorado study in the 1990s
- several studies have found that the tort system is quite good at compensating plaintiffs with meritorious claims
- other studies show that the key predictor of payment was plaintiff's degree of disability, not the presence of negligence
- considering all patients with negligent injuries (not just those who seek compensation), the malpractice system is very inaccurate system of distributing compensation
- system is also very inefficient: 60% of spending goes to administrative costs (predominantly legal fees), twice the overhead rate for an average workers' compensation scheme
- empirical evidence on deterrence:
 - less work on this area
 - legal deterrence is hard to measure
 - subject to methodological criticism
 - mixed evidence
 - risk of litigation might encourage defensive medicine, but evidence is mixed

Is the new crisis new?

- tort crisis characterized by decreasing availability of insurance coverage and decreasing affordability of policies
- several factors played a role in the emergence of the crisis:
 - dramatic increases in payouts to plaintiffs since 1999
 - moderate increases in the frequency of claims in some states
 - economic downturn with negative impact on insurers' investments
 - imprudent business decisions by insurers
- factors behind increases in claim frequency and payout size:
 - greater public awareness of medical errors
 - lower levels of confidence and trust in the healthcare system
 - advances in medical innovation and increases in intensity of medical services
 - rising public expectations about medical care
 - greater reluctance among attorneys to accept lower settlements
- two policy issues distinguish the current crisis:
 - hospitals are less able to pass on cost increases due to malpractice litigation to payers
 - new patient-safety movement

The two cultures: malpractice law and patient safety

- tension between the malpractice system (punitive, individualistic, adversarial) and the patient-safety movement (nonpunitive, systems-oriented, cooperative)
- transparency and disclosure are very important in the patient-safety movement and are needed for prevention
- the patient-safety movement argues that most errors arise from faulty systems not from clinicians' incompetence or carelessness
- tort law targets individual physicians, assigning blame and compensation on the basis of proof of negligence
- concerns about malpractice litigation diminishes patient-safety activities
- physicians underreport errors and don't communicate with patients if they are afraid of litigation
- fear of litigation obstructs progress in patient safety

Tort reform

- classical tort reforms:
 - limit access to courts
 - modify liability rules to decrease the frequency of claims and size of payouts
 - caps on damages
- limit access to courts
 - screening panels
 - shortening statutes of limitation
- modify liability rules to decrease the frequency of claims and size of payouts
 - elimination of joint-and-several liability
 - legislation to reverse judicial expansions of liability
 - elimination of the res ipsa loquitur doctrine
- caps on damages
 - cap on total or only on noneconomic damages
 - regulate attorneys' fees
- some alternatives:
 - collateral source offsets
 - periodic payments
- empirical findings suggest that tort reform can reduce frequency of claims and size of payouts
- data suggests that litigation does not promote patient safety or the accurate and fair distribution of compensation

Reform of the system

- alternatives for achieving compensation and deterrence:
 - using alternative mechanisms to resolve disputes
 - dispensing with negligence as the basis for compensation (no-fault)
 - locating responsibility for accidents at the institutional level (enterprise liability)

- alternative mechanisms to resolve disputes:
 - early-offer program: incentivize patients and the health care organization to negotiate private settlement immediately after adverse event
 - route malpractice claims through structured mediation, administrative law hearings, or medical courts
 - private contracts: e.g., agree to submit to arbitration in the event of an injury
- dispensing with negligence as the basis for compensation
 - would emulate workers' compensation
 - could give an administrative body the power to judge compensation for all medical-injury claims
 - carve out certain classes of events from the tort system and fast track them to compensation
 - replace determination of negligence with determination of avoidability
 - a larger pool of injuries would be eligible for compensation
 - could bring tort system closer to the patient-safety movement
- locating responsibility for accidents at the institutional level
 - enterprise assumes primary responsibility for any claims
 - would underscore systemic approaches to quality improvement